

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN1929	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 02/25/2016
NAME OF PROVIDER OR SUPPLIER VANCO MANOR NURSING AND REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 813 S DICKERSON RD GOODLETTSVILLE, TN 37072			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
N 000	Initial Comments During complaint investigation of #37516, 37598 and 37977 conducted on 2/9/16 through 2/25/16 at Vanco Manor Nursing and Rehabilitation Center, no deficiencies were cited in relation to the complaints under 1200-8-6, Standards for Nursing Homes.	N 000			

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

6509

OKM911

If continuation sheet 1 of 1